Thunder Bay Regional Health Sciences Centre

VASCULAR SERVICES REFERRAL FORM

Patient Name:_____

Date of Birth (dd/mm/yyyy):_____

Health Care Number:_____
(including version code)

Address:_____

City/Postal Code:_____

Telephone:_____

Is the patient hearing impaired? ☐ Yes ☐ No
Does the patient require a translator? ☐ Yes ☐ No Preferred Language: _____
Patient capable of giving their own Informed Consent? ☐ Yes ☐ No
Is Non-Insured Health Benefits (NIHB) travel required for this appointment? ☐ Yes ☐ No ☐ Unknown

GUIDELINES FOR USE:

1. Complete patient information box in top right corner. Affix chart label when appropriate. Please verify most responsible contact information for patient. Incorrect patient information could result in delay of assessment.
2. This form is to be completed for **ALL** referrals requiring Vascular Surgeon assessment including Rapid Access to Vascular Evaluation (RAVE) and non-urgent/routine referrals.
3. Section 1 and Section 2 is to be completed by **referring Physician/Nurse Practitioner.** Referring Physician/Nurse Practitioner contact information **must** be available on this form.
4. Please attach the following**: updated medication list, completed medical history, any previous intervention (antibiotics intravenous/per os/topical, wound care), all relevant diagnostic imaging NOT available via Sectra PACS at TBRHSC (CT/Ultrasound/XRay), wound culture results,.**
5. Fax referral to Surgical Central Intake- Vascular at (807) 684-9561. If you have questions about a referral, please call the Coordinator of Cardiovascular Services at (807) 684-6206.

Section 1 – Reason for Referral

The following represent **EMERGENT cases- please contact the on-call Vascular Surgeon through Switchboard at TBRHSC** and **complete** the following referral form. The on-call Vascular Surgeon is ALWAYS available to discuss acute or unusual vascular findings.
Name of Vascular Surgeon contacted:_____

☐ Symptomatic carotid stenosis
☐ Symptomatic aneurysms of any type
☐ Acute limb ischemia
☐ Acute arterial dissection

For all other vascular referrals, please complete the referral form:

Thoracic or Abdominal Aortic Aneurysm
☐ Less than 5cm, no symptoms
☐ Greater than 5cm, no symptoms
☐ Chronic dissection
☐ Asymptomatic Carotid Stenosis

Other aneurysms (any size)
☐ Iliac
☐ Popliteal
☐ Mesenteric (including renal)

Lower extremity occlusive disease
☐ Asymptomatic
☐ Claudication
☐ Rest pain
☐ Chronic limb threatening ischemia
(sores, fissures, ulcers, gangrene, non-healing wounds)

Upper extremity Ischemia
☐ Asymptomatic or Claudication
☐ Arterial steal
☐ Rest pain
☐ Tissue loss

Venous Disease

☐ Varicose veins without ulcers
☐ Varicose veins with ulcers

Other *(free text)*

Section 2 – Past Medical History

☐Complete medical history note, updated medication list, and relevant diagnostic imaging (if not available via Sectra PACS at TBRHSC) is attached

☐Prior Vascular Surgery (include procedure / physician)_____

Referring Physician (please print):_____ Date:_____

Referring Physician Signature:_____

Referring Physician Contact Information:_____